2020-2022 Community Health Needs Assessment and Implementation Plan
New London

Healthy Individuals Start with Healthy Communities

When people have access to the supports they need to realize their full potential, communities and individuals thrive. This starts with access to basic needs such as nutritious food, safety, humane housing and top-quality healthcare. Yet, a community that fosters health and well-being is so much more. There exist ample opportunities for lifelong learning, meaningful work that provides fulfillment and covers the bills, accessible and affordable transportation, environments that encourage activity and recreation, and connection to others - providing a place for all to truly belong.

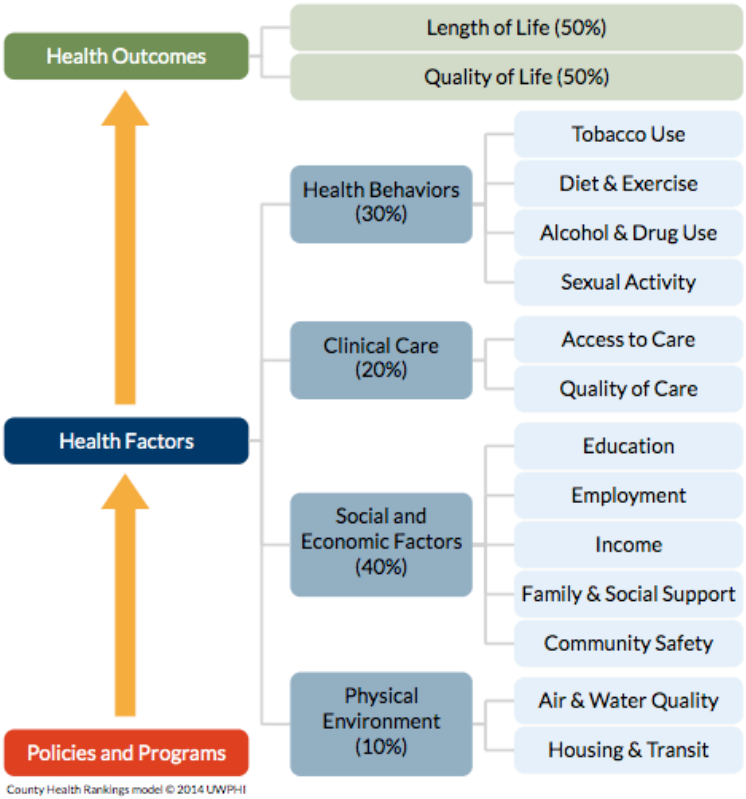
If this is what we know creates health, then this is where ThedaCare's interest belongs — upstream, helping to put in place, across the communities we serve, the conditions that build health in the first place. No longer simply a health*care* organization, ThedaCare is evolving into a *population health* organization, challenging the antiquated systems that incentivize more procedures over preventative measures. Customers of health services across Northeast and Central Wisconsin want to live healthier, more meaningful lives. It's ThedaCare's purpose to help them do just that.

The World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

The best models today suggest only 20% of health is created inside the walls of healthcare systems. That means that 80% of health is a result of what happens in our homes, our workplaces, our schools, our faith institutions, our communities. (See graphic below.)

ThedaCare uses the UW Population Health Institute model below to help build understanding of what creates health and to classify health needs and opportunities. Data collected through the Institute's County Health Rankings serve as one of several data sets that help us understand local health needs.

ThedaCare



The three-year plan that follows is a blueprint for how ThedaCare intends to leverage its exceptional talents inside its walls to team up with community partners across sectors to strengthen the health and well-being within the communities it serves and lay the foundation for health for generations to come.

About ThedaCare

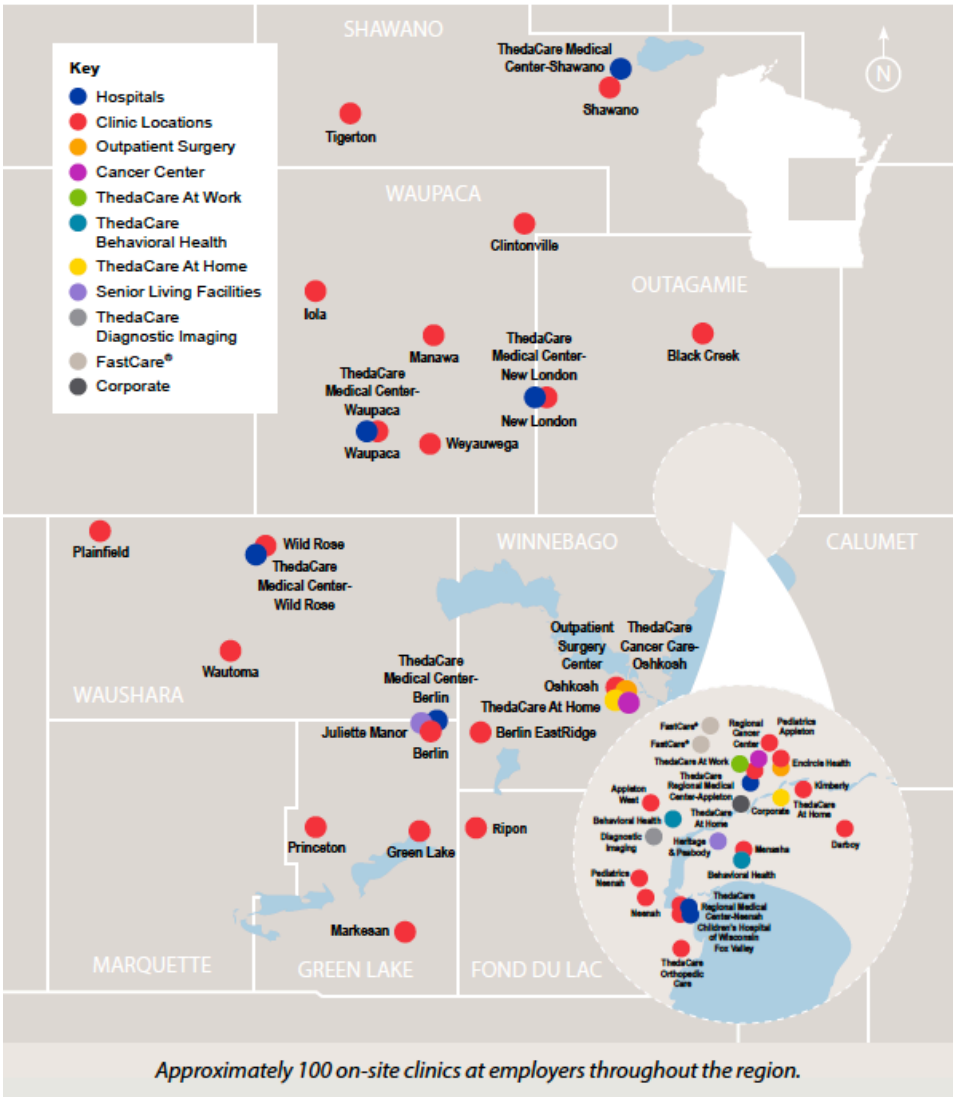
ThedaCare is the region's only locally owned, not-for-profit health system. That means ThedaCare decision-makers, inclusive of leaders, staff and board members, work in this community and call this place home. They have every reason to put the well-being of area residents first because each has a vested personal interest in the current and long-term health and vitality of family, neighbors and friends.

With deep roots dating back more than 110 years, ThedaCare has been committed to improving the health of the communities it serves in Northeast and Central Wisconsin. Each year, ThedaCare's 7,000 team members provide expert medical care to more than 250,000 individuals through more than 180 points of access including seven hospitals located in Appleton, Neenah, Berlin, New London, Shawano, Waupaca and Wild Rose, 35 clinics and ancillary sites, and 100 worksite locations. ThedaCare serves a region of more than 600,000 residents across 14 counties and features a level II trauma center, comprehensive cancer treatment, stroke and cardiac programs as well as a foundation dedicated to community service. In addition, ThedaCare is the first in Wisconsin to be a Mayo Clinic Care Network Member, giving our specialists the ability to consult with Mayo Clinic experts on a patient's care.

ThedaCare®

Locations Map

ThedaCare®



Approximately 100 on-site clinics at employers throughout the region.

Care that Spans Beyond Hospital and Clinic Walls

Well before the Affordable Care Act required health systems to conduct Community Health Needs Assessments and develop corresponding plans, ThedaCare was leading the way in community health improvement efforts. Since 2001, ThedaCare has used its Community Health Action Team (CHAT) model to bring community members together to study critical health needs and co-create effective, sustainable solutions. Leaders across all community sectors, including education, business, healthcare, government, non-profits, faith organizations, and more, participate in day-long field trips called “plunges” to learn firsthand from people with lived experience. This up-close perspective has empowered communities to take ownership of their health and fueled an urgent desire to craft collaborative solutions that have resulted in dozens of high-impact organizations and programs that are building health across the region.

ThedaCare has been a driving force behind development of such efforts as *Imagine Fox Cities* living vision, LiveWell Fox Valley creating a culture of health, the Rural Health Initiative taking care to the farm, the STAR Program reducing the gap in graduation rates between black and white youth, and so much more. As a result, the American Hospital Association and Baxter Health Foundation have twice recognized ThedaCare among the top four candidates in the country for the Foster G. McGaw Prize for Excellence in Community Service.

This commitment to the broader health of the community starts with a Board of Trustees that sees itself as stewards of individual and community well-being. A leadership team puts patient and community health at the center of everything ThedaCare does to ensure this work is embodied in our mission, our vision, our strategy and our plans. Dedicated Community Health staff are resourced to effectively research community need and develop partnerships and solutions that have impact. And, CHAT Teams in each community help ensure that local needs are not overlooked and proposed solutions will matter.

Community Health Needs Assessment

The Health of Our Community Today

Understanding the health of the community goes beyond data collection and analysis. It entails meeting face-to-face with and listening to the stories of people who live and work in the community, especially people whose voices may be easily overlooked. In what ways are their lives becoming healthier? What stands in their way to achieving health and well-being? What do they need to enhance their ability to lead healthy lives? These are all important questions that, coupled with data, paint a picture of opportunity for action.

Needs Assessment and Prioritization Process

ThedaCare’s Community Health Needs Assessment process was anchored by an Advisory Team of more than 40 community members and ThedaCare professionals from across the nine-county health system primary service area. (See Appendix A.) These individuals represented public health, non-profit organizations, ThedaCare hospitals and clinics, ThedaCare at Work and ThedaCare Board of Trustees. This group established a multiple-meeting process that

defined the purpose of the Assessment, the data to be collected and through what methods, laid out how the hospital and community would come together to make sense of the data, and what process would be used to prioritize identified needs and opportunities.

A Core Data Set developed by the Wisconsin Association of Local Health Departments and Boards (WALHDAB) was used as the starting point for secondary data collection. Public health assessments and plans were reviewed. In addition, interview data, gathered in partnership with all county and city health departments, was layered on, as were data collected through the Fox Valley Community Health Improvement Coalition (FVCHIC), a collaboration of all five health systems and public health organizations in the tri-county region. The FVCHIC conducted a joint behavioral risk survey of 1400 adults and parents of youth, along with 70 interviews of key stakeholders and vulnerable populations to reduce duplication of effort among health organizations. ThedaCare Community Health staff and public health conducted an additional 50 interviews of key stakeholders and vulnerable populations in rural hospital markets to complement the Fox Cities interviews and secondary data. (See Appendix B for list of key stakeholders interviewed.) Final components of the data set included hospital patient data, as well as input from the CHAT teams in each hospital market.

Three 4-hour data workshops were held to make sense of the primary and secondary data and prioritize opportunities. In addition to the Advisory Team, an expanded list of community and ThedaCare representatives was engaged in these workshops to ensure conclusions were accurate and relevant. (See Appendix C.) Representatives from each hospital service area reviewed their market-specific data and formed conclusions. This data was compiled to provide both regional and local landscapes of health need.

Priorities were identified using Impact and Feasibility Criteria. Specific criteria included the number of people affected, how likely to cause death, current trend and comparison to other state and national benchmarks, impact on vulnerable populations, importance to the community, and evidence of success in addressing the issue.

Common Needs Across the ThedaCare Service Area

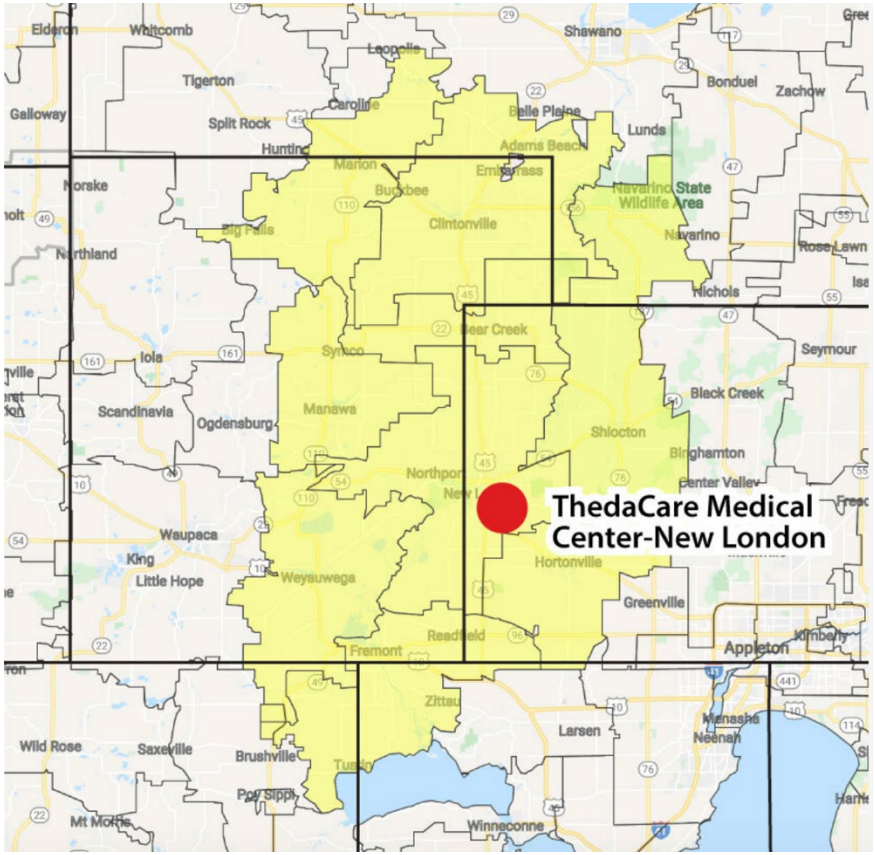
Several themes were consistent across all seven ThedaCare hospital markets. The most significant themes were:

- The average age of residents is increasing and their needs are becoming greater
- Health disparities are significant for people living in rural areas, low-income and people of color
- Adults and youth are struggling to maintain mental health
- Excessive drinking is among the highest in the state and country while drug use is growing with devastating effects on individuals and families
- Obesity and chronic disease are becoming the norm in Northeast Wisconsin
- Lack of access to dental care results in excessive emergency department visits
- Despite low unemployment and growth in household income, families still struggle to support basic needs, including healthcare
- Families are struggling to provide young children with the safe and healthy start needed for lifelong physical and mental health
- Disparities in educational attainment are significant for children in low-income families
- Transportation is a significant barrier to active living and needed services, particularly in rural areas
- Not everyone feels they belong in their community or have needed social supports

About ThedaCare Medical Center–New London

At the height of The Great Depression, a group of dedicated Canadian nuns living and working in New London moved from operating a small hospital out of a house to building a new facility that today serves residents as ThedaCare Medical Center–New London. As New London grew, the hospital grew along with it. Today, ThedaCare Medical Center–New London is a 25-bed critical access hospital serving New London and nearby communities primarily in Outagamie and Waupaca counties. The hospital offers an array of inpatient and outpatient services with access to 37 specialties keeping expert care close to home.

ThedaCare Regional Medical Center–New London Service Area



ThedaCare Medical Center–New London provides healthcare services to people throughout Wisconsin's Wolf River region, including New London, Clintonville, Manawa, Hortonville, Marion, Weyauwega, Shiocton, Fremont and Embarrass. New London's service area spans the border of Outagamie County and extends into Waupaca County. (Map represents zip codes of at least 80% of inpatient base).

For purposes of this plan, and to avoid duplication with other ThedaCare hospital markets, we will restrict our focus of ThedaCare Medical Center–New London's assessment and plan to primarily Waupaca and Outagamie counties.

Demographics

Population

The New London service area is located primarily in Waupaca County, but also includes the western portion of Outagamie County. The population of Waupaca County is just over 52,000. The population of Outagamie County is nearly 183,000. The majority of Outagamie County population is outside of the ThedaCare Medical Center–New London service area. Approximately 24% of Outagamie County served by ThedaCare Medical Center – New London is rural.

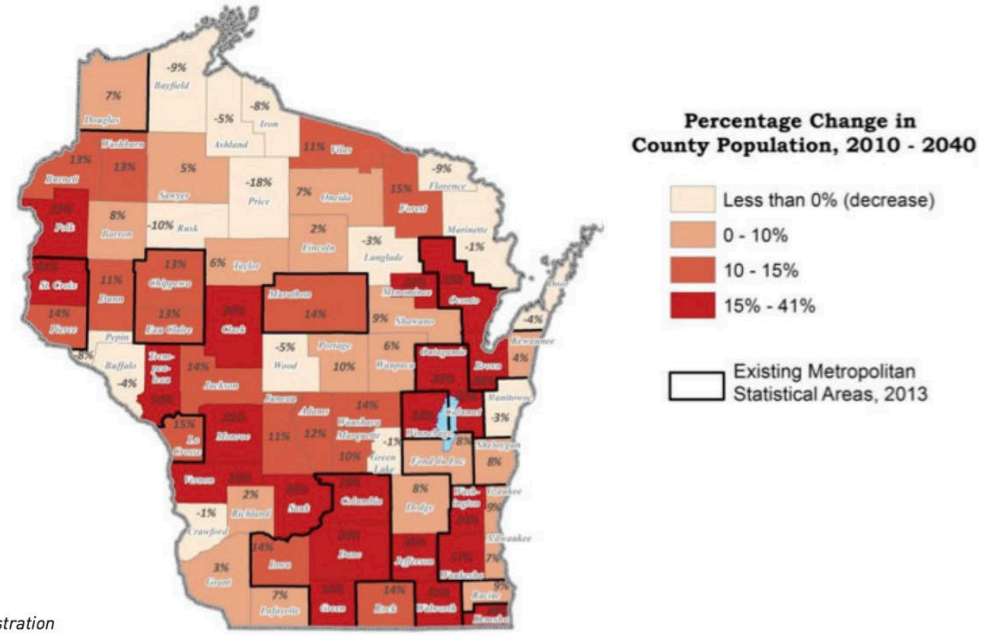
Waupaca County's population, which is concentrated in the western portion of the city of New London and in the city of Waupaca, is mostly rural (64.9%) with a large farming population in the northeast region. Waupaca County's natural growth rate of births compared to deaths since 2010 was - 2.1%. Net migration for Waupaca County, the difference between the number of people who move into the county and the number of people who leave, is 2.0%, offsetting the negative natural increase rate.

Natural growth rate for Outagamie County is at 3.2% births compared to deaths and net migration is at 0.1%.

Waupaca and Outagamie County Projections, 2010 - 2040

According to the Wisconsin Department of Administration, Waupaca County's population is predicted to grow slowly and reach peak population growth in 2030.

At the same time, Outagamie County is expected to continue to grow at a significant rate, moving from the 6th to the 5th largest county in the state by 2040.



Source: Wisconsin Department of Administration Demographic Services Center

Population Projections					
	2010	2020	2030	2040	Net Change
Waupaca	52,410	54,475	57,460	55,670	3,260
Outagamie	176,695	191,635	208,730	215,290	38,595

Population Projections Department of Administration, State of Wisconsin, 2015
Wisconsin Economic and Workforce Profile, 2017

Age Distribution

The average age of Waupaca County residents is significantly higher than the Wisconsin state average. Waupaca County has 22.7% of the population age 65 and older, compared to the 16.5% Wisconsin state average, and 29.5% of county population in the 45-64 age group, compared to a state average of 27.4%. With a median age of 44.4 years, Waupaca County is the 24th oldest county in the state out of 72.

The population of Outagamie County is concentrated in the Fox Cities urban area. Outagamie County's population growth rate has been significant compared to other counties in Wisconsin. Outagamie County overall has a smaller percentage of residents 65 and older (14%), compared to the Wisconsin average (16.1%), and a higher percentage of younger residents under 18 (23.5%), compared to state average (22.1%).

Total Population (2018 est.)					
	0-17	18-44	45-64	65+	Total
Waupaca County					
Total for Group	10,367	14,539	15,364	11,825	52,095
Percent of Total	19.9%	27.9%	29.5%	22.7%	
Outagamie County					
Total for Group	42,965	63,820	50,566	25,645	
Percent of Total	23.5%	34.9%	27.6%	14.0%	182,996

Source: www.countyhealthrankings.org (PEP), (ACS, 2011-2015).

Race/Ethnicity

Outagamie and Waupaca Counties have a significantly higher percentage of Non-Hispanic white population (88.0% and 94.6% respectively) compared to the Wisconsin average (81.7%). Outagamie County has 4.2% Hispanic population, compared to 3% for Waupaca County. The difference in ethnic populations between counties is more pronounced in the Asian population, where Outagamie County Asian residents total 3.4%, compared to 0.5% for Waupaca. Outagamie County also has a higher population of Non-Hispanic African Americans, at 1.2%, compared to 0.4% for Waupaca County.

Population by Race/Ethnicity*		
	2014 (est.)	2018 (est.)
Waupaca		

Non-Hispanic White	96.0%	94.6%
Hispanic	2.6%	3.0%
Native Hawaiian/Other Pacific Islander	0.0%	0.0%
Asian	0.4%	0.5%
American Indian and Alaskan Native	0.0%	0.7%
Non-Hispanic African American	0.3%	0.4%
Outagamie		
Non-Hispanic White	89.0%	88.0%
Hispanic	3.7%	4.2%
Native Hawaiian/Other Pacific Islander	0.0%	0.1%
Asian	3.1%	3.4%
American Indian and Alaskan Native	1.8%	1.9%
Non-Hispanic African American	1.0%	1.2%

*As some census respondents choose not to disclose ethnicity, percentages may not equal 100% of the population.
Source: www.countyhealthrankings.org (PEP)

Income Level

Waupaca County's average household income ($52,100) is below the $56,800 state average, while Outagamie County's average household income ($61,800) is above state average.

About 11% of the Waupaca County population and 7% of Outagamie county population lives below 100% of the Federal Poverty Level. From 2013 to 2018, Outagamie County's population living below the Federal Poverty Level has stayed consistent and below state average. The percentage of families living below the Federal Poverty Level in Waupaca County has decreased from 2013 to 2018 but remains higher than the Wisconsin average.

According to United Way, 36% of Waupaca County and 30% of Outagamie County households live below the Assets Limited, Income Constrained, Employed (ALICE) and poverty thresholds. ALICE represents individuals and families who are working but are unable to afford the basic necessities of housing, food, childcare, health care, and transportation. This is less than the state average of 37.5%.

For Waupaca County, 7% are uninsured with 6% uninsured in Outagamie County.

The percentage of children eligible for free and reduced school lunch is rising in the New London market. Waupaca County (41%) is just above the state average of 40%, and Outagamie County (31%) is below the state average for free and reduced lunch.

Waupaca and Outagamie counties are each below the state average of 16% for children living in poverty, with Outagamie County having one of the lowest child poverty rates (10%) across all nine ThedaCare counties.

Median Household Income		
	2013	**2018**
Waupaca		
Median Household Income	$47,601	$52,100
Outagamie		
Median Household Income	$56,901	$61,800

Source: www.countyhealthrankings.org (SAIPE) , United Way

Vulnerable Population Groups

The Community Health Needs Assessment identified several vulnerable populations, including the following key potential targets for our strategy:

- Single-parents
- Low income
- Those living with a disability
- Farmers
- Older adults
- Veterans
- Homeless populations
- Hispanic/Latino population

Our plan addresses health needs of the broader population with a special focus on members of the more vulnerable populations identified above.

Key CHNA Findings

New London Market Community Health Needs Assessment **General** *indicates data applicable to the New London market AND the entire nine-county service area* ***New London market*** *indicates data specific to the New London service area*		
Demographics		
Conclusions	**Data/Interviews that back this up**	**Implications**
Average age of our population is getting older – disproportionately affecting rural areas	**What the data says:** **General** • With exception of Calumet, all counties saw negative change in population age 0-17 • With exception of Green Lake, all counties saw positive increase in population age 65+ • Senior populations are growing faster than the state average **What the community says:** **General** *"Many folks retire here for the peace and quiet and then age and become frail or have other health issues and then need help accessing services. How do they do this when they can't drive, don't have access to more specialized services that they need?"*	• Demand for daily living support and healthcare will increase • Transportation and social isolation concerns will increase • Health needs of Baby Boomers will place greater demands on "sandwich generation" • Fewer babies are being born, particularly in rural areas. Forcing healthcare to adjust provider mix. • Declining workforce capacity
While the population is predominantly white, diversity is increasing slowly	**What the data says:** **General** • The Non-Hispanic White population has decreased between 0.8-1.5% across all markets in the last 5 years. The largest non-White populations are Hispanic in rural markets and Hispanic, Asian and African American in urban areas. Native Americans accounts for 82.9% of Menominee County population • As a percent of population, Menominee (5.8%), Waushara (6.4%) and Green Lake (4.8%) have the largest Hispanic populations by county • The Asian population is concentrated in urban	• Types of health needs will become more varied requiring cultural sensitivity and competence across community services • Hispanic community is not seeking services due to political climate • Need to grow trust with diverse populations

	counties • The African American population is still well below state average (6.3%) across all markets ranging from 0.4% in Shawano and Waupaca to 2% in Winnebago and Waushara • The Native American population comprises 83% in Menominee and 8.2% in Shawano. All other counties are below 2% **New London market** • 34% of Tri-County stakeholder interviews listed racial and ethnic diversity among top 5 areas for improvement **What the community says:** **General** *In the next 5 years, the community would be healthier if…" we would address racism."*	
Health Outcomes **Length and quality of life**		
Conclusions	**Data that backs this up**	**Implications**
Health outcomes across service area among most to least healthy in state	**What the data says:** **General** • CHR Outcomes range from #9 of 72 for Calumet to #72 of 72 for Menominee **New London Market** • Outagamie ranks #16 of 72 counties for Health Outcomes • Waupaca ranks #50 of 72 counties for Health Outcomes **What the community says:** n/a	• A wide array of factors create different health outcomes across our service area. Strategies to address health may need to vary by urban vs rural and among different sub populations
Health disparities exist for those living in rural areas	**What the data says:** • Only the urban counties of Calumet (#9 of 72), Winnebago (#28 of 72) and Outagamie (#15 of 72) appear in the top half of health outcomes rankings	• Across health factors, including access to care, income levels, education, access to recreation facilities, etc…rural areas are more challenged to lead healthy lives

	• People living in rural counties have more years of potential life lost before age 75 per 100,000 population than the state average (6,100) **What the community says:** **General** *"Lack of availability of services in rural area makes it difficult for people to access specialty care or mental health care. Those without transportation really struggle."*	
Adults and youth are struggling to maintain mental health	**What the data says:** **General** • Self-reported number of mentally unhealthy days in past 30 days has been increasing across markets since 2012, (with the exception of Calumet and Winnebago). The number of days range from 3.1 (Calumet) to 5.8 (Menominee) • Mental health was identified by key stakeholders as among top three health problems across all seven hospital markets **What the community says:** ***"****The issues of mental health are addressed somewhat above, but people don't seek care due to availability/transportation and stigma."*	• There is no health without mental health. Mental and physical health are intertwined. • Declining mental health affects all aspects of life including family and friend relationships and workplace productivity. • Adverse Childhood Experiences are major cause of mental health issues. • Declining mental health, hopefulness, ability to cope leads to increased substance abuse. • Our youth are struggling to cope with life stressors and need enhanced protective factors including resiliency, knowledge, communication, relationships and support. • Entire families, schools and communities are seriously impacted by suicide ○ Sends message to other youth that suicide is an answer to their problems. • Demand for mental health services will grow, including at earlier ages
Diabetes rates are high in our service area	**What the data says:** **General** • The percent of adults age 20+ with diagnosed diabetes is at or above the state average (9%) across all markets **What the community says:** *"Obesity leads to other problems – diabetes, cancer, aging problems (mobility, access, socialization); heart disease/stroke top death in county; mental health"*	• We can anticipate an increase in health implications including heart disease, stroke, kidney disease, hypoglycemia, neuropathy, eye problems and more. Also, will likely reduce life expectancy • Will increase demand for healthcare services

Falls among older adults are an increasing cause of death	**What the data says:** **<u>General</u>** • In six of nine counties, fatal falls exceeds the state average of 410 per 100,000 population in 2016 • Falls was not listed among top health needs across key stakeholders. Falls was only cited twice among all interview candidates. **<u>New London market</u>** • Only Waushara, Waupaca and Outagamie were below state average for falls **What the community says:** **<u>General</u>** *"Aging is interesting – kind of vague, does capture a lot of the patients seen in ED - dementia, falling, patients want to live in homes, challenging to ensure safety and caregiver to help them."*	• Falls are not only a risk factor for fractures, they can lead to irreversible health, social, and psychological consequences, with profound economic effects • More falls are likely with aging population.
Cerebrovascular disease hospitalization rates are high	**What the data says:** • 2015 Cerebrovascular Disease Hospitalization Rate is higher than the state average of 11.3 per 1,000 population in five of eight counties (No data available for Menominee). Calumet, Waushara and Winnebago were only three below state average **What the community says:** n/a	• Strokes can result in death or serious disability including loss of cognitive functions, partial paralysis in some limbs, speech difficulties, memory loss and more. • Higher incidence may require expanded rehab and therapy services to recover functioning for the patient as well as support services for family care providers

While new diagnoses of cancers are better than the state across most markets, the incidence of various types of cancer is increasing. Urban vs rural data varies. Nationally, incidence of certain cancers is increasing at a younger age due to obesity epidemic.	**What the data says: (Incidence per 100,000)**
	• Cancers declining across markets
	  ○ Colorectal
	• Cancer increasing across markets
	  ○ Oral
	  ○ Melanoma – incidence higher than state average in six of seven counties for which have data
	  ○ Uterine – incidence rising in five of seven counties for which have data
	• Cancer above state average in Urban
		• Cancer rates are generally higher in urban areas with exception of lung cancer which is higher in rural areas.
		• Signals importance of early detection and screening as well as focus on root cause related to diet, exercise and tobacco.

	○ Breast ○ Ovarian ○ Prostate – incidence declining across markets; higher than state average in urban • Cancer above state average in Rural ○ Lung – declining across markets; above state average in some rural • Nationally, cancer incidence significantly increased for six of 12 obesity-related cancers (multiple myeloma, colorectal, uterine corpus, gallbladder, kidney, and pancreatic cancer) in young adults (25–49 years) with steeper rises in successively younger generations **New London market** • Melanoma, ovarian and prostate cancer rates exceed other areas **What the community says:** **General** *"Cancer – not sure what is causing – not a factory causing pollution…"*	

Health Behaviors
Individual actions that impact health

Conclusions	Data/Interviews that backs this up	Implications
Excessive drinking (includes binge and heavy drinking) is among highest in state and country	**What the data says:** **General** • Excessive drinking surpasses national benchmark by more than two times across all markets • Urban markets, including Outagamie county, have highest Excessive Drinking rates at 24-29% **New London market** • Alcohol-impaired driving deaths have been declining across markets with the exception of Green Lake and Waupaca counties. Four counties exceed the state average of 36% – Winnebago (38%), Waupaca (43%), Calumet (44%) and Menominee	• Excessive drinking contributes to other health factors including violence, motor vehicle crashes/deaths, increased STIs, increased suicide and mental health issues, and chronic disease • Alcohol abuse is an Adverse Childhood Experience, fostering cycle of long-term health implications • Healthcare providers can play a greater role in screening and referral

	(56%) **What the community says:** **<u>General</u>** *"Additional prevention, education and a reduction of alcohol being at virtually every community event would be better for the community"*	
The consequences of drug use are becoming more serious leading to more fatalities and hospitalizations. Drug use among adults appears to be increasing, impacting children and families. Opioids and heroin continue to plague communities. Marijuana is becoming more socially acceptable among youth	**What the data says:** **<u>General</u>** • Drug abuse was named among top three health problems across all markets • Drug overdose death rate in Northeast Wisconsin has quadrupled from 2000 to 2016, rising from 2.7 deaths/100,000 population in 2000 to 12.5 deaths/100,000 • The rate of opioid related hospital discharges in Northeast Wisconsin has more than doubled in the last 10 years, from 122/100,000 population in 2006 to 331/100,000 in 2016 • The heroin poisoning discharge rate has jumped from 0.6/100,000 population in 2007 to 16.1/100,000 population in 2016 • Wisconsin foster care placements due to caretaker drug use have risen from 15% of placements in 2012 to 29% of placements in 2016 • Number of opioid prescriptions written in Wisconsin declined by 32% in past year • Hepatitis C rates are higher than state average of 68 per 100,000 population across all markets with exception of Calumet **What the community says:** **<u>General</u>** "*Opiate abuse and Mental Health as well as Domestic Abuse are biggest health concern. These issues and how they affect the children in households with parents that are experiencing these issues*	• Along with the individual impacts of drug use, the societal impacts are increasing as well such as children in families not receiving the parent support they need; Foster care demand is rising; burglary and theft increasing as drug users seek to fund drug habits, for example • Demand for prevention, treatment and recovery services grows • Drug abuse is an Adverse Childhood Experience, fostering cycle of long-term health implications
While cigarette use is declining among	**What the data says:**	• Most e-cigs contain nicotine, which is addictive and can

youth, vaping is dramatically on the rise and kids and parents don't know the risks	**2018 Tri-County Youth Data Only** • 27% of youth report vaping in the past month, up from 18% in 2016. This is significantly above the state average of 12%	harm the developing brains of kids and could affect memory and attention • Some brands contain additional chemicals that can be dangerous
Tobacco use among pregnant women is high	**What the data says:** **General** • Tobacco use is at or below the state average of 17% across all markets except Menominee (33%) • Smoking rates among pregnant women is above state average of 13% across all markets with exception of Outagamie (11%) and Calumet (9%) **What the community says:** **General** *"More pregnant women are addicted to drugs and tobacco use."*	• Increase in low birth-weight babies • Increased rates of asthma, chronic lung disease, cancer, stroke
Overweight and Obesity continue to increase reaching new epic levels year after year • Access to physical activity limited • Fruit and veg consumption declining • Access to affordable healthy foods declining	**What the data says:** **General** • Self-reported obesity levels are rising across all markets and exceed the national benchmark of 25% across all markets • Self-reported obesity levels meet or exceed the state average of 31% across all markets with the exception of Outagamie County (30%) • Adults who report no leisure time physical activity exceeds state average of 21% across all markets with exception of Winnebago and Outagamie • Only two counties report exceeding the state average of 86% who live reasonably close to a location for physical activity — Winnebago (90%) and Outagamie (93%) • Fruit and vegetable consumption has declined by 5% in Winnebago, 14% in Outagamie and 12% in Calumet from 2015 to 2018 • Youth fruit and vegetable consumption has declined 16% in Winnebago and 3% In Outagamie; Calumet has increased %.	• Rates of chronic disease increase including cardiovascular disease, Type II diabetes, cancers, hypertension, osteoarthritis, sleep apnea, etc. • Poor quality of life due to obesity can lead to depression and/or other mental health issues • Increase in demand for healthcare services

	<u>2018 Data from Tri-County Area only</u> • Only 10% of youth reported eating the recommended two fruit/three vegetables servings in last 7 days • The percentage of youth reporting getting two or fewer hours of screen time on average school day declined from 33% in 2016 to 25% in 2018 **What the community says:** *"People with more money have better health, lots of food insecurity and poverty, @ 60% free reduced lunch"*	
Youth risky sexual behavior rising in some markets	**What the data says:** **<u>General</u>** • While teen sexual intercourse is declining (27% have ever had sex), the percent of sexually active youth reporting using a condom is 55%, below the state average of 63%. Earlier YRBS data suggest not using a condom is high across some markets including Marquette (26.7% of HS seniors who've had sexual intercourse) and Outagamie (25.2%). Data not available for all counties • 9% of sexually active youth report no method used to prevent pregnancy **<u>New London market</u>** • The percent of illegal tobacco sales to minors is more than two times the state average **What the community says:** *"Alcohol and other drug abuse lead to risky sexual behaviors"*	• Increase in STDs/STIs, Hep C, HIV and long-term health • Risk of teen pregnancy
Clinical Care **Access to Quality Health Care**		
Conclusions	**Data/Interviews that backs this up**	**Implications**
Hospitalization rate for ambulatory-sensitive conditions is improving across almost all markets; however rates	**What the data says:** **<u>General</u>** • Hospitalization rate for ambulatory-sensitive	• High rate may suggest access to care or insurance issues • Significant opportunity to treat people at a lower level of

continue to be higher in rural vs. urban markets	conditions range from 33-39 per 1000 Medicare enrollees in urban markets vs. 39-106 in rural counties • Ratio of population to primary care physicians exceeds state average in six of nine counties; however a mix of urban and rural. (Does not include other providers such as NPs and PAs) **What the community says:** n/a	acuity
A large number of people across markets are not receiving dental care. Many show up in the Emergency Department in crisis	**What the data says:** **General** • The percentage of people age 2+ that did not receive a dental visit in the past year meets or exceeds the state average of 26% in five of nine counties, including Waupaca • While improving across all markets, the ratio of population to dentists exceeds the state average in six of nine counties, including Waupaca. Many dentists do not accept Medicaid patients, or accept very limited number • The percent of Medicaid members receiving a dental service in past year is declining across all counties and is worse than state average in five of nine counties including Waupaca • Oral disease is top Level 5 acuity Emergency Department visit by volume in six of seven hospitals **What the community says:** **General** *"I put all accesses to care together but if I have to pick one, access to dental would be top need, only 2 dentists in county, neither accept Badgercare/Medicaid/ Medicare"*	• Poor dental health increases risk of inflammation, infection and hardening of arteries decreasing blood flow • Untreated dental issues often result in expensive emergency department visits, driving up the cost of care
While uninsured rates have declined across markets, many people are still not accessing care due to out of pocket	**What the data says:** **What the community says:**	• Health needs go unaddressed until reaching critical levels at which point more expensive and intensive care may be needed

cost, transportation, political climate or other access issues	**General** *"Insurance barriers prevent many patients from getting appropriate care and/or having extended hospital admissions."*	
Many children across the service area are not receiving recommended healthcare services including Well Child checks and immunizations	**What the data says:** **General** • 25% of children in ThedaCare system do not attend all 7 Well Child visits in first 15 months • Childhood immunization rates are below state average of 73% across all rural markets **What the community says:** **General** *"One strategy I recommend to improve the health of the community is to educate people about immunizations. This is a top health concern."*	• Children with developmental delays or early health concerns may not receive the support needed for the optimal start to life • New parents may not receive the support needed; may feel more isolated and stressed increasing risk of child abuse and neglect • Not receiving vaccinations leads to reduced immunity and increased risk of life-threatening disease for individual and community
While population to MH provider ratios are improving across all markets, access to timely mental health and AODA services remains a major concern	**What the data says:** **General** • Access to affordable mental health care was among the top three social determinants of health people are most concerned about across all markets • The ratio of population to mental health providers exceeds the state average in eight of nine counties **New London market** • A Waupaca dental clinic opened this year as part of the Partnership Community Health Center, increasing access to dental care • The ratio of population to mental health providers is more than three times the state average in Waupaca County **What the community says:** *"I think poor mental health resources, stigma, and limited access due to insurance issues makes mental health not only the primary concern here, but it is behind some of the other issues: alcoholism, suicide, etc."*	
Socioeconomic Factors		

Underlying Causes of Health/Health Behaviors		
Conclusions	**Data/Interviews that backs this up**	**Implications**
A greater percentage of families across all markets are struggling to financially support their basic needs, despite employment and growth in household income. Children and people living in rural markets are particularly vulnerable	**What the data says:** **General** • Poverty is listed among top three social determinants of greatest concern in eight of nine markets • With the exception of Winnebago, the percentage of families living below the Assisted Living, Income Challenged, Employed (ALICE) and poverty level rose in every market from 2014 to 2016. Rural markets are all above state average of 38% Percents range from 29% of families in Calumet to 62% in Menominee • Median household income is below state average of $56,800 across rural markets • The percent of children eligible for free school lunch is rising across markets and exceeds the state average of 40% in six of nine counties • The percent of children living below the Federal Poverty Line exceeds the state average of 16% in all rural markets with the exception of Waupaca **What the community says:** *"We have many jobs available, but they do not pay a living wage and often no benefits. This leads to a variety of poor health outcomes. We have to begin working on better paying jobs in the area and transportation to those positions."*	Health and healthcare is not a priority for people living in poverty. Attention to basic needs is. Health issues are often ignored until they reach crisis level. Then the ED serves as primary care access Poverty is a root cause or barrier to many health problems including mental health
Educational attainment among adults in rural markets is significantly below urban markets and state average	**What the data says:** **General** • All rural counties are dramatically below state average/national benchmark of 68% of adults age 25-44 with some college or associate's degree **What the community says:** n/a	• Lower educational attainment levels are associated with diminished levels of health. Adults with higher levels of education are less likely to engage in risky behaviors, such as smoking and drinking, and are more likely to have healthy behaviors related to diet and exercise
Economically disadvantaged youth	**What the data says:**	• High school graduates tend to lead longer and healthier

across all markets are at higher risk of not graduating high school	**General** • While 4-year graduation rates are holding steady, the 4-year graduation rate of economically disadvantaged youth is 15-20 percentage points below the rates of economically advantaged. **What the community says:** n/a	lives than their peers who drop out, partly due to a graduate's ability to earn more money and afford better health care and housing in safer neighborhoods. Graduates also have an opportunity to learn and practice more about healthy behaviors.
Children across markets are struggling with reading, especially those who are economically disadvantaged	**What the data says:** **General** • The percent of economically advantaged 4th grade students reading at proficient levels is below state average of 60% across counties with the exception of Winnebago and Green Lake. Percentages for economically disadvantaged students are significantly lower than for economically advantaged students across markets. (Menominee data not available) **What the community says:** n/a	• A student who can't read on grade level by 3rd grade is four times less likely to graduate by age 19 than a child who does read proficiently by that time. Add poverty to the mix, and a student is 13 times less likely to graduate on time than his or her proficient, wealthier peer *http://blogs.edweek.org/edweek/inside-school-research/2011/04/the_disquieting_side_effect_of.html*
A significant percentage of people across the service area are dealing with multiple Adverse Childhood Experiences	**What the data says:** **General** • Seven of nine counties report 10% or more of the population having 4+ Adverse Childhood Experiences, with exceptions of Shawano and Calumet **What the community says:** n/a	• An ACE score of 4 or more increases risk for chronic diseases such as heart disease, lung disease, cancer and diabetes by 3.9x. High ACE scores also increase risk for depression, substance abuse, and other mental health conditions
Safety of youth is declining	**What the data says:** **2018 Data from Tri-County Area only** • The percent of youth who report they feel they belong in school declined from 71% in 2016 to 67% in 2018 • The percent of youth reporting emailing or texting while driving in past month, 54%) exceeds state average of 46% and national average of 39% • 20% of youth agree/strongly agree that violence is a	

	problem at school • 11% report they did not attend school at least one day is last month because did not feel safe • 10% of youth report physical dating violence; 12% report sexual dating violence **What the community says:** n/a	
Families are struggling to maintain stable home environments	**What the data says:** **General** • From 2012 to 2016, the number of children in out-of-home care in Wisconsin (not including Milwaukee County) has increased 25% **New London market** • Waupaca County has experienced a significant increase in graduation rates **What the community says:** **General** *"Parents are not parenting properly - not sending kids to school. Parents having mental health/drug problems. Drug problems increasing - particularly in workforce – can't pass drug test. Lots of stress."*	

Physical Environment
Environmental factors that contribute to health

Conclusions	Data/Interviews that backs this up	Implications
Access to quality housing is a challenge in several rural markets	**What the data says:** **General** • The percent of housing built prior to 1980 exceeds state average of 25.5% in Waupaca, Shawano, Green Lake and Winnebago **What the community says:** *"Not enough affordable housing"*	• Greater risk of lead poisoning, mold, asthma • Higher costs to heat and maintain • Increased risk of infestation, etc.
Transportation is a significant barrier to healthcare access as well as social supports, particularly in rural markets	**What the community says:** *"Transportation in the rural is critical.. Improvements in access, affordability and reliability in transportation*	• Lack of transportation limits ability to get to medical and other necessary appointments. It also leads to isolation and reduced well-being

	would improve outcomes."	
At least 10% of people in the service area struggle to access food	**What the data says:** **General** • In all but one county (Calumet), 10% or more of the population did not have adequate access to food during the past year **What the community says:** *"healthy foods improving, not in rural area; all access are issues"*	• Access to healthy food has a direct impact on health. Nutrition is critical to address many chronic diseases such as high blood pressure or diabetes. It is also essential to maintaining good health and prevention of disease
People living in rural markets are more challenged to find ways to be physically active	**What the data says:** **General** • Counties range from 0.04 facilities per 1,000 population in Waushara to 0.14 per 1,000 in Outagamie **What the community says:** **General** *"Lack of exercise is issue… not a lot of opportunity, rural county has less opportunities."*	• Lack of physical activity impacts both physical and mental health

Information Gaps

While we believe the volume and variety of data gathered to support the Community Health Needs Assessment was comprehensive, gaps in available data did exist.

- Not all school districts in our service area participate in the Youth Risk Behavior Survey. This limits information related to school-aged children.
- A local BRFSS survey is not conducted in this hospital market, so statewide results were used. This limited the ability to analyze results from some populations because sufficient data was not available.
- Limited data was available on the following:
    - Social support, relationships, connectedness, isolation
    - Vulnerabilities and resiliency of populations
    - Health literacy
    - Completed referrals from rural areas to regional medical centers

2020-2022 Priorities

Over the next three years, ThedaCare will focus on addressing the following top three health priorities as identified by the communities it serves:

- Mental health
- Substance use
- Obesity and chronic disease

Potential Resources to Address Prioritized Health Needs

Many healthcare facilities and services are available in Waupaca and Outagamie counties to respond to the health needs of the community and assist ThedaCare in achieving its mission. They include:

Healthcare Facilities and Community Resources
AA
ADRC
Ascension Health
Aurora
Catalpa Health
CESA 5 &6
Childrens Hospital of Wisconsin
Chrisitne Ann Center
City and County Law Enforcement
Drug Courts
Farm to School Program
Farmers Markets
Harbor House Domestic Abuse Shelter
Head Start
Healthy Beginnings
Living the Waupaca Way
Mosaic Family Health
NAMI
New London Chamber of Commerce
New London CHAT Team
New London Community Gardens
New London, Weymont, Clintonville, Manawa, & Marion Food Pantries
Options Counseling

Outagamie County Public Health
Partnership Community Health Center
Rawhide
Reach Counseling
Rural Health Initiative
Safe Routes to School
ThedaCare at Home
ThedaCare at Work
ThedaCare Behavioral Health
ThedaCare Physicians
University of Wisconsin Extensions
Waupaca County Public Health
Waupaca DHHS
Outagamie County DHS
Outagamie DHHS
FVTC
Faith Communities
PNCC
WIC
Waupaca Suicide Coalition
Goodwill
School districts of NL, Clintonville, Hortonville, Manawa, Marion, Shiocton, Freedom
Waupaca County Crime Stoppers
NL Chamber
NL Park & Rec
NL Homeless Shelter
Mission of Hope
Tyson
ECWRPC

Needs Identified and Not Addressed in This Plan

Significant needs identified through our assessment that will not be addressed in the current three-year plan are listed below.

Community Needs and Reasons Needs Not Addressed

Community Need	Why Not Addressed
ACES/Early Childhood	Work in this area has been initiated and is ongoing
Isolation/Community Connections	Work in this area has been initiated and is ongoing
Families struggling to maintain stable home environment/financial sustainability	Interwoven into existing work; partnering as resources allow

2017-2019 Community Health Implementation Plan Progress Report

(A detailed progress report on the 2017-2019 Community Health Implementation Plan through October 31, 2019 is included in Appendix D.)

ThedaCare received no written comments on the hospital's Community Health Needs Assessment or implementation plan.

Community Health Implementation Plan – New London

Plan Design Guiding Principles

In addition to ThedaCare's six principles that guide the delivery of care to patients and families every day, the following additional principles helped guide the development of this Community Health Implementation Plan:

- **Strive for a balanced portfolio of action**
  Creating a healthy community takes work on several fronts – addressing immediate physical and mental health needs while also considering the underlying social and spiritual needs and seeing people as more than a set of biometrics; enhancing the underlying community conditions that create health in the first place and leveraging the complete assets of our institutions to build healthy practice into how our organizations and institutions function within our communities.
- **Balance regional strategy with local ingenuity**
  Systemic initiatives can have powerful impact across the entire ThedaCare service area. At the same time, local CHAT teams have proven their ability to use less expansive, less bureaucratic, local relationships and creativity to launch innovative solutions to health problems that can be scaled across the region.
- **Embrace physical, mental, social health AND wellbeing**
  Traditional health assessments focus on the physical and mental measurements of health. However, new research acknowledges the significance of social connection to health as well as the significance of well-being, both individual and community perceptions of current and expected quality of life. Health rises and falls over time; while well-being persists over generations and is a strong predictor of need for acute services.
- **Rely on partners to achieve more**
  No one entity can improve the health and wellbeing of a community on its own. ThedaCare has a long-standing history or working in partnership with government, business, non-profits, faith organizations, school systems and even health system competitors to implement important health initiatives.
- **Build alignment between clinical care and community priorities**
  When clinical care is aligned with the needs and resources in the community, a seamless continuum of support emerges that helps ensure community members are getting the support and care they need to live their best possible life.
- **Increase use of data to inform community health decisions**
  While data is prolific, access to the right data to drive decisions regarding community health can sometimes be challenging. New pathways to data are emerging daily that can be tapped to focus community health efforts on people and places that can provide the greatest health returns.

Community Health Implementation Plan Measures

A shift is happening across our country and the world that recognizes the measurement of health as more than a set of physical and mental health status indicators. Health, we are learning, is also about a personal sense of well-being, including having hope for the future, a sense of purpose to life, and relationships that sustain us during trying times. These components of well-being contribute to health in additional, fundamental ways. As a result, measures of well-being are now being paired with more traditional physical and mental health indicators to provide a more robust view of personal and community health.

The measures below are Community Level Indicators of health and wellbeing across the region. These are adopted from the Wellbeing in the Nation work and are steadily being embraced as valuable measures of health and wellbeing throughout the nation. These measures are currently in place in parts of the ThedaCare service area. Effort will be made to capture this data throughout the entire region.

The measures below are intended to track success of collective goals shared by individuals and organizations that comprise the region. No one entity alone is responsible for these community-level outcomes, but ALL have a responsibility to contribute in their own unique ways to collectively help people live longer, healthier and happier lives. (Metrics for the individual actions included in this Implementation Plan have their own set of Program Level metrics identified in the following plans.)

Community Level Indicators
Adult Indicators
Well-Being Overall
Best possible life current
Best possible life future
Financial Well-Being
Current
Future
Physical Well-Being
Well-Being Index-Physical Health
Physically unhealthy days in past 30
Mental Well-Being
Wellbeing index-Mental Health
Mentally unhealthy days in past 30
Social Well-Being
Wellbeing index-
Receive Social Support Needed
Purpose
Wellbeing Index-Lead a Purposeful Life

Youth Indicators

General Health
- General health good, very good, excellent

Physical Health
- At least 3 days physical health not good in past month

Mental
- At least 3 days mental health not good in past month
- Sad/hopeless for two weeks

Social
- Family loves me and gives me support
- Belong in school

The plan put forth in this document is ThedaCare's commitment over the next three years to contribute to the improvement of the indicators above by specifically addressing the top three health priorities identified through the most recent Community Health Needs Assessment:

- Mental health
- Substance use
- Obesity and chronic disease.

The Strategy

The actions in the following plan support two distinct community health investment strategies that are in line with research conducted by ReThink Health, Boston, MA:

1. Investment in **Vital Conditions** that foster health and well-being of the collective community AND
2. Delivery of **Urgent Services** to address the immediate needs of those in crisis.

Both strategies are important in addressing the community health priorities of mental health, substance use, and obesity and chronic disease prioritized through ThedaCare's Community Health Needs Assessments. However, as communities invest more in Vital Conditions, the expectation is that need for Urgent Services declines. Belonging/Civic Muscle is the "glue" that engages community in fostering a culture of heath and meeting local needs.

ThedaCare

Vital Conditions

Basic Needs for Health and Safety

Humane Housing

Lifelong Learning

Thriving Environment

Meaningful Work and Wealth

Reliable Transportation

Urgent Services

Acute Care for Illness or Injury

Homeless Services

Addiction and Recovery Services

Environmental Clean-Up

Criminal Justice, Violence, and Emergencies

Unemployment and Food Assistance

Belonging and Civic Muscle

The Implementation Plan: An Ecosystem of Action

For simplicity's sake, the following plans appear somewhat linear with specific actions having unilateral impact on mental health, substance use, or obesity and chronic disease alone. However, we know that what creates health is actually quite complex and "messy." And, often actions taken today, such as preventing abuse or helping youth graduate high school, may not result in health outcomes for years to come.

It may be desirable to think of the plan that follows as more of an action ecosystem that, in collaboration with efforts of other individuals, organizations and institutions in our communities, weaves together a strategy that collectively builds the vital conditions that foster health and provides the services that lift up those with greatest need thereby strengthening our health and well-being today and for our future.

(Tactics listed in italics indicate ongoing efforts from previous plan.)

Goal #1

Establish a culture that fosters health and wellbeing and reduces incidence of chronic disease.

Vital Conditions addressed*: Basic Needs, Social Connection/Belonging, Environment and Reliable Transportation*

Result Experienced

People express a greater sense of well-being. They naturally build healthy eating and active living into their daily routine because the healthy choice is the easy choice. Incidence of chronic disease is decreased enhancing quality of life. People feel more socially connected and supported and report a greater sense of personal health and happiness.

The Story:

The percent of adults age 20+ with diagnosed diabetes is at or above the state average of 9% across the entire ThedaCare service area. Self-reported obesity levels are rising across all ThedaCare markets and exceed the national benchmark of 25% across all markets. In the Fox Valley, 75% of adults and 29% of children ages 3-18 are overweight or obese and these values continue to steadily increase. The estimated number of adults living with pre-diabetes in the Tri-county area is 107,685, or 34% of the population. The current cost to the healthcare system of providing care to adults w/ diabetes is estimated at $385,313,497, which doesn't account for pre-diabetes or future costs. Nationally, 86% of hospitalizations are due to chronic disease that is preventable. At the same time, self-reported mental health across the region has declined every year since 2012.

Needs assessment data relative to current health behaviors provides little hope that this trend will ease. Adults who report no leisure time physical activity

exceeds the state avg. of 21% across all markets, with the exception of Winnebago and Outagamie Counties. Adult fruit and vegetable consumption has declined between 5 and 14 percentage points in the past three years across the Tri-county area, while youth fruit and vegetable consumption also experienced significant decline. Only 10% of youth report eating the recommended servings of fruit and vegetables in the last 7 days. And, the percentage of youth in the Tri-County area reporting getting 2 or fewer hours of screen time on average school day declined from 33% in 2016 to 25% in 2018.

Over the past five years, the Weight of the Fox Valley coalition has brought together stakeholders across the Fox Cities tri-county region to combat these negative trends. However, due to several reasons - including having a narrow focus on weight vs. healthy living, limited funding, centralized vs. distributed leadership, program vs. policy focus, etc… - little tangible progress has been demonstrated. A 2018/19 reboot, led by health system leaders from ThedaCare, Ascension, Aurora, Network Health, and Children's Wisconsin, has transformed the initiative to build, over time, a culture of health and well-being in the region. Early on, work will center on a select, narrow focus and expand to scale as results are realized.

Action	Description	Partners	Metrics	TC Resources
Co-champion *LiveWell Fox Valley* as an anchor institution in partnership with area health systems and other community businesses and organizations. Spread model as appropriate to rural markets.	Multi-sector collaboration to advance a culture of health and well-being. Year one strategy centered on **"Food as Medicine,"** connecting diabetic/pre-diabetic residents with healthy foods while also enhancing the economic and social capacity of the community. Additional longer term strategies beyond year one include: • **Regional Systems Change** Collaboratives focused on food systems and recreation/transportation • **Healthy Local Settings** Work intensified in key places where people gather – schools, workplaces, hospitals, childcare, faith organizations and neighborhoods. • **Community-Clinical partnerships** Additional partnerships that screen	• Feeding America • Neighborhood Organizations • Ascension • Aurora • Children's Wisconsin • Network Health • United Way • Business • Public Health • Government • Education/Schools • Community Foundation • Basic Needs Giving Partnership • Faith Communities • Child Care Centers	Self-reported: ▪ Good physical health ▪ Good mental health ▪ ⇧ physical activity ▪ ⇧ # fruits + vegetables consumed ▪ Reduced incidence of Type II Diabetes ▪ Reduced blood pressure ▪ Reduced blood glucose ▪ BMI	**Labor: High** • ELT • CHI • CIN • Food Service • Operations • EVP *(2020-22)*

	patients and connect them to community resources.	• Wisconsin Health TIDE		

Additional New London Region ThedaCare efforts:

- Support local farmers' markets
- Support healthy kids events
- Sponsor Women's Wellness Day
- Offer healthy lifestyle classes
- Sponsor local runs/walks
- Conduct health risk assessment of all ThedaCare employees and partners

Community Health Action Teams (CHAT)

- Cross-sector CHAT Teams in each market may be used to develop new, innovative, collaborative solutions to this goal through CHAT plunges and follow-up action. Current New London CHAT efforts aligned with this goal include Trauma Sensitive Community education.

Employee Volunteer Program

- ThedaCare employs a workforce of 7,000 team members that have potential to support this goal through community volunteer opportunities.

Sponsorships and Contributions

- Local non-profit organizations may apply for limited funding for projects and programs aligned with this goal.

ThedaCare

Goal 2

Youth and adults have support needed to lead mentally healthy lives, free of reliance on harmful substances

Vital Conditions addressed: ***Social Connection/Belonging and Basic Needs***
Urgent Services addressed: ***Acute Care for Illness or Injury and Addiction and Recovery Services***

Result Experienced

Every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to their community. *(WHO definition of Mentally Healthy).* Developmental delays and Adverse Childhood Experiences are detected early, preventing a lifetime of physical and mental health ailments. People are generally resilient and positive. Alcohol and drug misuse are decreased leading to less trauma to individuals and families. People have access to the social supports and treatment services needed to withstand or overcome challenging circumstances.

The Story

- Adults and youth are struggling to maintain mental health. Adult self-reported number of mentally unhealthy days in the past 30 has been increasing steadily across all ThedaCare markets since 2012. Mental health was identified among the top three health concerns across all seven hospital markets.
- Youth in the Tri-County area:
  - 19% of youth have self-harmed in the past year, above the state average of 17%.
  - 25% of youth have felt sad or hopeless every day for at least the last two weeks.
  - 47% of youth report having a significant problem with feeling very anxious, nervous, tense, scared or something bad is going to happen, over the past year. This is above the state average of 40%. Only 22% of these youth report getting help when needed.
  - 16% have seriously considered suicide in the past year; 6% have actually attempted, down from 9% in 2016
  - The national pre-kindergarten expulsion rate was 6.7 per 1,000 pre-kindergarteners enrolled. This rate is 3.2 times higher than the national rate of expulsion for K-12 students, which is 2.1 per 1,000 enrolled.
- Access to affordable mental health care was among the top three social determinants of health people are most concerned about across all markets.
  - The ratio of population to mental health providers exceeds the state average in 8 of 9 counties in ThedaCare service area.
- 7 of 9 counties report 10% or more of the population having 4+ Adverse Childhood Experiences (ACEs).
- From 2012 to 2016, the number of children in out-of-home care due to parental drug use in Wisconsin (outside Milwaukee) increased 25%.
- While opioid related deaths are levelling due to increased access to Narcan and tighter prescribing practices, Substance Use Disorder continues to remain high - Native Americans, African Americans/Black, and males are disproportionately affected.

- Lack of social connection has been shown to have a comparable impact on health to smoking 15 cigarettes a day. 1 in 3 adults in Winnebago County study report they do not receive the social support they need.

Action	Description	Partners	Metrics	TC Resources
Improve access to Behavioral Health treatment within ThedaCare to divert patients from higher levels of care, keep patients close to home, and promote long-term recovery and overall resiliency.	Improve access to Behavioral Health treatment throughout ThedaCare system by expanding services provided, using technology, advancing practice models and expanding the geographic footprint of care. Specific initiatives include: ▪ Behavioral Health Urgent Care ▪ Expansion of treatment in rural settings ▪ Expansion of telehealth ▪ Expansion of the Collaborative Care model	▪ TCBH ▪ Government ▪ IS ▪ Primary Care ▪ DHS County Services ▪ ED ▪ Critical Access Hospitals	• Patient visits/volume within TCBH • # Patients served through Collaborative Care model • # providers using telehealth	**Labor: High** • TCBH • CIN • IS • Facilities *(2020-22)*
Support Sources of Strength in high schools	Expand Sources of Strength (SoS) beyond Fox Cities to rural high schools across service area. SoS is evidence-based peer to peer model proven to address suicide, mental health, substance use and bullying. Increases willingness to reach out for help and build social connection.	▪ Schools ▪ Sources of Strength National ▪ NEW Mental Health Connection	▪ % students report sad/hopeless for 2 weeks ▪ % consider suicide ▪ % report belonging at school ▪ % report they can identify a trusted adult	**Labor: Low** ▪ *CHI* ▪ *TCBH* *(2020-22)*
Support Start-Up of Recovery/Peer Specialist support model	Develop community-clinical partnership to provide immediate recovery support to individuals in overdose/crisis enhancing possibility for enrollment in treatment and/or accessing needed supports to become/stay substance-free.	▪ Local AODA agencies ▪ State of Wisconsin ▪ Funders ▪ Bellin	• # visits to ED • #/% ○ Remain sober ○ On MAT ○ Reduce use ○ Trying/ Relapse	**Labor: High** • CHI • TCBH • IS • EDs (*2020-22)*

Support Assessment of Efficacy of Regional Substance Use Coalition	Support the NEW Mental Health Connection in researching potential start-up of data-driven regional substance use backbone organization to address prevention, education, access, workforce and advocacy. The goal is to help guide vision and strategy around shared measurement of the impact of substance use in our community.	▪ NEW Mental Health Connection ▪ Catalpa Health ▪ Health Systems ▪ Recovery Agencies ▪ Winnebago County Drug & Alcohol Coalition ▪ Public Health	• Decision made to launch/not launch regional coalition with vision and priorities identified	**Labor: Low** ▪ CHI ▪ TCBH *(2020-22)*
Promote a proactive approach to identifying and treating behavioral health needs through consistent screening and referral	Embed consistent and standardized screening and referral processes for behavioral health treatment across the ThedaCare system, specifically within primary care, ED and specialty services. The following screeners will be utilized or explored for utilization across the system: ▪ ASQ and ASQ S/E ▪ ACEs Screening ▪ PHQ-9 ▪ GAD ▪ Columbia-Suicide Severity Rating Scale (C-SSRS) ▪ Alcohol/Drug Screening	▪ EDs ▪ Quality ▪ Primary Care ▪ Specialty Services ▪ Community-Based Agencies ▪ Public Health ▪ Early Childhood Coalitions	• % appropriate patients screened through each screener • % of positive screened patients referred and followed up with referral	**Labor: High** ▪ CIN ▪ CHI ▪ Population Health ▪ TCBH ▪ Emergency Department ▪ IS *(2020-22)*
Support operations of NEW Mental Health Connection through leadership, space and	*Partner with other major organizations and funders to support this essential backbone organization. NEW MH Connection will be leading the following projects:*	▪ *NEW Mental Health Connection* ▪ *MH Agencies* ▪ *Health systems*	▪ *TBD*	**Labor: Low** • *TCBH* • *CHI* • *Emergency*

funding	***Zero Suicide:*** *Creates adult suicide death review; offers Zero Suicide training for healthcare professionals on front lines; address adult resiliency in workplace (i.e. SoS for middle age white males); assist with systemic process improvement for handling suicide situations* ***Qualitative Study on Youth Suicide*** *using participatory community-based research re: causes of suicide.* ***Healthy Teen Minds*** *– Includes Sources of Strength (above); Sleep, Social Emotional learning in early childhood; Screening through website.*	▪ *Schools* ▪ *Public Health*		*Departments* *(2020-2022)*
Support mental health of children and youth through Catalpa Health	*Partner with area health systems to support the operations ability of Catalpa Health to provide mental health services to area children and youth.*	▪ *Catalpa Health* ▪ *Ascension* ▪ *Children's Hospital of Wisconsin*	▪ *# of children served* ▪ *Access to therapy* ▪ *Access to Psychiatry* ▪ *Investment per child* ▪ *Outcomes as measured by ACORN* ▪ *Patient satisfaction* ▪ *Referral source satisfaction*	**Labor: Low** • *TCBH* • *ELT* *(2020-2022)*

Additional ThedaCare efforts:

- Support Drug Treatment Court
- Support mentoring programs
- Support Drug Drop Box promotion
- Subsidize ThedaCare Behavioral Health services
- Support PARTY at the PAC
- Support ACEs and Trauma Informed Care education
- Conduct health risk assessment of all ThedaCare employees and partners

Community Health Action Teams (CHAT)

- Cross-sector CHAT Teams in each market may be used to develop new, innovative, collaborative solutions to this goal through CHAT plunges and follow-up action. The New London CHAT Team is currently supporting the development of a transportation initiative to help people access services and enhance social connection.

Employee Volunteer Program

- ThedaCare employs a workforce of 7,000 team members that have potential to support this goal through community volunteer opportunities.

Sponsorships and Contributions

- Local non-profit organizations may apply for limited funding for projects and programs aligned with this goal.

Goal 3

The most vulnerable populations within ThedaCare service area have the opportunity to achieve optimal health and wellbeing

Vital Conditions Addressed: ***Basic Needs, Meaningful Work/Wealth, Humane Housing, Lifelong Learning, Reliable Transportation, Belonging and Civic Muscle***

Result Experienced

All people have access to the services and supports they need to lead healthy lives for themselves and their families. All children are raised in environments that have access to resources needed to provide a solid start to life. Differences in health outcomes among urban vs. rural, non-white vs. white, low-income vs high-income and other vulnerable populations are reduced. People are able to work in jobs that provide dignity and livable wages and can afford adequate housing and enough nutritious food for themselves and their families. Lives are less stressful and people feel they belong and are engaged in shaping their neighborhoods and communities.

The Story

- **Urban vs. Rural-** According to County Health Ranking data, all three urban counties in ThedaCare service area rank in the top half of WI counties for health outcomes and health factors, while all 6 rural counties rank in the bottom half. People living in rural counties have more years of potential life lost before age 75 per 100,000 population than the state average of 6100. Significant disparities exist between urban vs. rural health related to poverty rates, reading proficiency, educational attainment, access to care, smoking, access to recreational facilities, transportation, food insecurity, and more.
- **Race -** People of Color (POC), in particular Native Americans, African Americans and Latino populations, experience disproportionate rates of chronic disease, smoking, drug use, poverty, educational attainment, among other factors, in the ThedaCare service area.
- **Poverty -** People living in poverty are at increased risk for mental illness, chronic disease, higher mortality, and lower life expectancy. The risk for chronic conditions such as heart disease, diabetes, and obesity is higher among those with the lowest income and education levels. In addition, older adults who are poor experience higher rates of disability and mortality. Finally, people with disabilities are more vulnerable to the effects of poverty than other groups.

Action	Description	Partners	Metrics	TC Resources
Implement Social Determinants of Health	Build process to systematically screen for Social Determinants of Health across	• 2-1-1 • Non-Profit Agencies	• % patients screened • % patients with a need	**Labor: High** • Clinically Integrated

Implement Screening and Referral for Social Needs such as housing, food, transportation, social isolation, utilities.	primary care and ED services and connect patients with community supports. Ensure follow-through with attaining support and documentation in EMR. Providers trained in SDoH and Trauma Informed Care.	• United Way • Application Vendor • Public Health	referred to service • % of referred patients with completed referral and documentation in EMR	Network (CIN) • Quality • Population Health • ACO • IS Department/EPIC • Care Management/ Community Health Workers • Community Health • Emergency Department *(2020-21)*
Support Basic Needs Giving Partnership/POINT Regional Poverty Initiative	*Play leadership role in partnership to align local funding behind key drivers of poverty, including social connection, employment, education, and health. Develop POINT as R&D arm of BNGP to provide support to community agencies and collaborations addressing key drivers of poverty and design experiments re: poverty solutions.*	• *US Venture* • *JJ Keller* • *Oshkosh Corp.* • *Thrivent* • *GB, FV and Oshkosh Community Foundations* • *Non-Profits* • *United Ways*	• *Jobs metrics* • *Poverty metrics* • *Funded project metrics*	**Labor: Medium** • *ELT* • *CHI* *(2020-22)*
Expand role/scope of Rural Health Initiative	Expand scope of RHI to enhance rural access to care, early detection and management of chronic disease, healthy lifestyle education, and connection of unassigned frequent ED patients to primary care home.	• Rural Health Initiative • Agri-Businesses • Public Health • Non-Profits	• # undiagnosed chronic disease detected • # referrals to TC primary care • Reduction in chronic disease	**Labor: Medium** • Population Health • CHI • TCMC-Shawano • CIN • Care Management *(2020-22)*

Provide new parents with parenting resource information and connection	Develop Welcome Baby model for all new parents in collaboration with area health systems to help ensure parents have access to resources to provide a strong start to their child's life.	• Family Services
		• Aurora
		• Ascension
		• First Five Fox Valley
		• Children's Hospital
		• OB/Gyns
			• #/% of first time parents receive Welcome Baby Visit
			  ○ #/% short term follow up
			  ○ #/% referred for assessment
			  ▪ #/% long term follow up (Home Visitation)
				Labor: High
				• **CHI**
				• **CIN**
				• **Birth Centers**
				
				(2021-2022)

Explore Education Savings Incentive early childhood model	Partner with community organizations to research, design and, if feasible, implement 2-generation incentive model that increases chances for long-term life and academic success by providing a nurturing early childhood home environment and academic financial incentives.	• Community Foundation • First 5 Fox Valley • Family Services • County Services/ Birth to 3 • Head Start • Catalpa Health • United Way • Community Health • Public Health • Financial Institution/529 Plan administrator	• Increased likelihood child will attend college • Improved parenting knowledge and skills • Increased kindergarten readiness • Improved financial well-being	• CHI • TC Family of Foundations • CIN/FP/Peds • Birth Centers • EVP *(2021-2022)*

Additional ThedaCare efforts:

- Support parent education efforts
- Provide Caring Hearts charity care and absorb Medicaid losses for those unable to pay
- Support area Chambers of Commerce
- Support area non-profits addressing poverty such as Mission of Hope
- Support programs to enroll patients and community members in benefits
- Implement Reach Out and Read program in all child-serving primary care clinics
- Support ACEs and Trauma Informed Care education

Community Health Action Teams (CHAT)

- Cross-sector CHAT Teams in each market may be used to develop new, innovative, collaborative solutions to this goal through CHAT plunges and follow-up action. The New London CHAT Team is currently supporting the development of a transportation initiative to help people access services and enhance social connection.

Employee Volunteer Program

- ThedaCare employs a workforce of 7,000 team members that have potential to support this goal through community volunteer opportunities.

Sponsorships and Contributions

- Local non-profit organizations may apply for limited funding for projects and programs aligned with this goal.

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Goal 4

The internal and external systems, structures and supports necessary for execution of the Community Health Implementation Plan are in place.

Result Experienced

The region has an expressed vision and sense of priorities that guide policy-level and investment decision-making across all sectors. Investments in vital conditions that create health would be increased and less fragmented; while need for investments in acute crisis services would be diminished. More people would express a greater sense of health and well-being, making the region a destination for new businesses, families and individuals seeking an enhanced quality of life. A shared approach to measurement of health and well-being exists across the region and health system, public health and community plans are in greater alignment. ThedaCare is viewed as an indispensable champion and willing partner in helping a vision of health come to be.

The Context

Over the course of the last two years area leaders facilitated a process to engage diverse community members to articulate a vision for the health and well-being of its citizens for generations to come. That vision serves as a "North Star" to align community investments to make this vision a reality. This work has drawn the attention of national leaders in health and well-being, such as Robert Wood Johnson Foundation, ReThink Health, and 100 Million Healthier Lives, placing ThedaCare and the region on the cutting edge of advancing health in the country. Efforts to build ownership of the vision across all sectors, municipalities, organizations, groups, and individuals spanning the region will help improve the probability that progress toward the vision will be achieved and health and well-being will be improved.

A critical component in achieving this vision is the alignment of the health organizations in the region, including health systems and public health. Local health systems and public health departments have a history of working together in a limited fashion to collect data for their respective needs assessments. However, significant opportunity exists to more closely align their assessment and measurement processes to reduce duplication and collectively prioritize opportunities. A common community health improvement agenda does not exist in the region today. Such an agenda, aligned with the broader *Imagine Fox Cities* vision, would galvanize partners and resources to focus on the critical few opportunities for greatest impact. This vision process could be expanded to engage the larger ThedaCare service area.

The same applies to the CHAT Teams existing within each ThedaCare market. CHAT Teams are comprised of community leaders across all sectors who help

create understanding of local health conditions and co-create solutions that have local buy-in and lasting impact. Currently, each CHAT Team chooses its own focus among the ThedaCare Community Health Priorities at any point in time, creating a competing pull for system resources. In addition, no structure exists to share learnings among communities and scale up effective initiatives across the ThedaCare service area.

Inside ThedaCare, Population Health has been identified as the system's strategy. New partners, such as b.well, will provide enhanced channels for exploring community health innovations.

ThedaCare is THE locally-owned, non-profit health system that engages in community health like no other. Opportunity exists to lay claim to this differentiation and to utilize the power of 6700+ team members to participate in and tell our story.

Action	Description	Partners	Metrics	TC Resources
Co-champion area visioning initiative and pilot *ReThink Health Portfolio Design Lab*.	Provide leadership support to *Imagine Fox Cities* visioning initiative to develop common, living vision and sense of priorities across Fox Cities region. Challenge established investments in community structures to more effectively improve health and well-being through participation in *ReThink Health Portfolio Design Lab* demonstration project supported by RWJF. Position Fox Valley on cutting edge of well-being and community development in the nation. Engage 9-county service area as appropriate.	• Local Governments • Business • United Way • Community Foundation • ReThink Health • 100 Million Healthier Lives • RWJF • Community Initiatives	• Living Vision exists • Process developed and implemented to enact change • Diverse new leaders identified • Investment portfolio aligned with vision	**Labor: Med-High** **ELT and CHI engagement** *(2020-22)*
Co-champion aligned regional CHNA/CHIP process	Build a process that brings together health systems, public health, and other community partners to conduct collaborative needs assessment and community health improvement plans that align, addressing collective priorities of the region.	• Public Health • Ascension, Aurora, Children's Hospital of Wisconsin • Partnership Community Health Center • *Imagine Fox Cities*	• CHNA/CHIP process developed and followed by all PH and Health Systems	**Labor: High** • CHI • CIN • Population Health *(2021)*

		• United Ways • Community Foundations • Business • Non-Profits • Government		
Restructure CHAT Model	Restructure CHAT model to create greater alignment of priorities, enhance innovation, build community goodwill, improve efficiencies, share learnings, and take effective solutions to scale across markets.	• CHAT Teams • Community leaders	• Impact metrics of health initiatives • # scaled up initiatives	**Labor: Med-High** • Hospital presidents • Population Health • CHI • TC Family of Foundations *(2020)*
Establish consistent measurement of health and well-being	Establish consistent common set of metrics of health and well-being across the ThedaCare service area.	• Public Health • Health Systems • United Way	• Common set of metrics	**Labor: Med** • CHI *(2021)*
Develop Community Health Communication Strategy	Work with brand/communications to develop consistent strategy to create awareness both internally and among key external stakeholders of ThedaCare's Community Health work.	• Communications agency	• # of communications • Reach and frequency • Surveys	**Labor: Med** • Brand/ Communications • CHI *(2020-2022)*

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APPENDIX

Appendix A

Community Health Needs Assessment Advisory Team 2018

Advisory Team Member	Organization
Tim Galloway	CHAT/TC Foundations/Galloway Company
Maureen Markon	CHAT/TC Foundations; Waupaca School District
Brenda Haines	Consulting
Kristene Stacker	Partnership Community Health Center FQHC
Vicki Dantoin	Public Health–Shawano/Menominee
Mary Dorn	Public Health–Outagamie County
Cathy Ellis	Public Health–Calumet County
Doug Gieryn	Public Health–Winnebago County
Nancy McKenney	Public Health–City of Menasha
Bonnie Kolbe	Public Health–Calumet County
Kurt Eggebrecht	Public Health–City of Appleton
Kathy Munsey	Public Health–Green Lake County
Jayme Sopha	Public Health–Marquette County
Patty Wohlfel	Public Health–Waushara County
Jed Wohlt	Public Health–Waupaca County
Julia Carroll	Public Health–Green Lake County
Bill Schmidt	ThedaCare Medical Centers–New London and Shawano
Tammy Bending	ThedaCare Medical Centers–Wild Rose and Berlin
Dr. Dave Krueger	ThedaCare ACO
Patty Vanbeek	ThedaCare at Home
Gina Augustine	ThedaCare at Work
Jim Meyer	ThedaCare Board of Trustees
Dr. Doug Moard	ThedaCare Board of Trustees
Ryan McCartney	ThedaCare Brand, Marketing, Communications
Dr. Jennifer Frank	ThedaCare Clinically Integrated Network
Don Waldrop	ThedaCare Clinically Integrated Network
Randy Roeper	ThedaCare Clinically Integrated Network
Paula Morgen	ThedaCare Community Health

Kaye Thompson	ThedaCare Community Health
Jean Blaney McGinnis	ThedaCare Community Health
Tracey Ratzburg	ThedaCare Community Health/Children's Hospital of Wisconsin
Laura Owens	ThedaCare Data Resources
Brian Sterns	ThedaCare Executive Leadership Team
Julia Garvey	Partnership Community Health Center FQHC
Phil Hollar	ThedaCare Medical Center–Emergency–Shawano
Tracy Jurgens	ThedaCare Medical Center–Emergency–Shawano
Ashton Reno	ThedaCare Medical Center–Emergency–Appleton
Kelly Smudde	ThedaCare Medical Center–Emergency–Berlin
Ann Younger Crandall	ThedaCare Medical Center–Emergency–Neenah
Shane Kohl	ThedaCare Family of Foundations
Jodie Rietveld	ThedaCare Information Systems
Dr. Kay Theyerl	ThedaCare at Work
Peter Kelly	United Way Fox Cities
Rachel Podoski	United Way Fox Cities

Appendix B

Key Stakeholder and Vulnerable Population Interviews

New London Service Area	
Jesse Cuff	Waupaca County Veteran's Service Office, Service Officer
Mary Dorn	Outagamie County, Public Health Officer
David Holst	Outagamie County Veterans Service Office, Service Officer
Kristina Ingrouille	WIC Director, Waupaca
Shannon Kelly	Waupaca County DHHS, Deputy Director
Leah Klein	Waupaca County ADRC, Manager
Chuck Price	Waupaca County DHHS, Director
Brian Randall	Gold Cross Ambulance, Community Paramedic
Patricia Sarvela	Partnership Community Health Center, Administrator
Jeffrey Schlueter	New London Police Department, Chief
Laurie Schmidt	New London School District, Director of Pupil Services
Thiago Souza	Waupaca County, Economic Services Manager
Rhonda Strebel	Rural Health Initiative, Executive Director
Greg Watling	First United Church, Pastor
Mary Wisnet	United Way Fox Cities, Vice President
Andrew Wittmann	Waupaca County Park & Recreation, Director
Jed Woldt	Waupaca County, Health Officer

Appendix C

Community Health Needs Assessment Data Workshop Participants 2018

Name	Organization	Hospital Market
Ryan McCartney	ThedaCare	All
Mary Ann Siebert	ThedaCare	All
Gina Augustine	ThedaCare	All
Randy Roeper	ThedaCare	All
Brian Sterns	ThedaCare	All
Tracy Ratzburg	ThedaCare	All
Jeanine Knapp	ThedaCare	All
Wendy Krueger	ThedaCare	All
Shane Kohl	ThedaCare	All
David Krueger	ThedaCare	All
Kay Theyerl	ThedaCare	All
Don Waldrop	ThedaCare	All
Julie Meyer	ThedaCare	All
Catherine Ellis	Calumet County Public Health	Appleton
Heidi Keating	Outagamie County Public Health	Appleton
Kurt Eggebrecht	City of Appleton Public Health	Appleton
Kimberly Barrett	Lawrence University	Appleton
Montgomery Elmer	ThedaCare	Appleton
Dennis Episcopo	Appleton Alliance/Common Ground	Appleton
Kristene Stacker	Partnership Community Health Center	Appleton and Neenah
Rachel Podoski	United Way Fox Cities	Appleton and Neenah
Beth Clay	NEW Mental Health Connection	Appleton and Neenah
Nancy McKenney	City of Menasha Public Health	Appleton and Neenah
Mary Dorn	Outagamie County Public Health	Appleton and New London
John and Sally Mielke	Mielke Family Foundation	Appleton and Shawano

Tammy Williams	Community Foundation	Appleton, Neenah and New London
Mindy Collado	Boys & Girls Club	Berlin
Katie Gellings	Green Lake County Public Health	Berlin
Julia McCarroll	Green Lake County Public Health	Berlin
Kathy Munsey	Green lake County Public Health	Berlin
Kelli Tarlton	ThedaCare	Berlin
Tammy Bending	ThedaCare	Berlin
Kelly Schmude	ThedaCare	Berlin
Jaime Sopha	Marquette County Public Health	Berlin
Tammy Bending	ThedaCare	Berlin and Wild Rose
Doug Gieryn	Winnebago County Public Health	Neenah
Jodie Rietveld	ThedaCare	Neenah
Kari Smith	ThedaCare	Neenah
Tim Galloway	Galloway Company	Neenah
Greg Watling	First United Church	New London
Ginger Arndt	City of New London	New London
Bill Schmidt	ThedaCare	New London and Shawano
David Corso	ThedaCare	New London and Waupaca
Jed Wohlt	Waupaca County Public Health	New London and Waupaca
Margo Dieck	Waupaca County Public Health	New London and Waupaca
Becky Heldt	Clean Slate	Shawano
Vaughn Bowles	Menominee Tribe	Shawano
Tracy Jurgens	ThedaCare	Shawano
Nick Mau	Shawano and Menominee County Public Health	Shawano
Vicki Dantoin	Shawano and Menominee County Public Health	Shawano

Philip Hollar	ThedaCare	Shawano
Myrna Warrington	Menominee Tribe	Shawano
Drew Lacefield	Independent Counselor	Shawano
Julie Chikowshi	ThedaCare	Shawano
Chris Anthony	Community Foundation	Waupaca
Maureen Markon	Waupaca School District	Waupaca
Heidi Cuff	ThedaCare	Waupaca
Jesse Cuff	Waupaca Veterans Services	Waupaca
Sue Heideman	Volunteer	Waupaca
Amanda Williams	ThedaCare	Waupaca and Wild Rose
Brian Friebel	Family Health LaClinica	Wild Rose
Stacey Westphal-Dunn	Waushara County	Wild Rose
Patti Wohlfeil	Waushara County Public Health	Wild Rose
Jeff Martz	Martz Insurance	Wild Rose
Jennifer Sigourney	ThedaCare	Wild Rose
Mary Ann Schilling	UW Extension–Waushara County	Wild Rose
Tom Rheinheimer	Wautoma School District	Wild Rose

Appendix D

Community Health Implementation Plan 2017-2019 Progress Report

Early Childhood/Youth Goal: *Children age 0-5 in ThedaCare 9-county service area have a healthy start to life.*				
Community Level Indicators • *4th Grade Reading Proficiency* • *Child Abuse and Neglect Rate* • *Well-child visit % (TC Pop Health)*				
	Baseline 1/1/17	**Target 12/31/19**	**Current 11//19**	**The Why**
Action: Reach Out and Read				The well-being of young children was identified as one of top health concerns in 2015 and 2018 CHNAs. Improving early childhood addresses root cause of multiple long-term physical and mental health issues. Reach Out and Read is
• Number of TC clinics ○ Fully implemented ○ In training	4 of 27 clinics 0	25of 25 0	23 of 25 clinics 2 All 25 expected to complete training by 12/31/19	

• Book distribution ○ Number of books ○ Rate -% of eligible well child visits where book handed out	5,115 89%	23,194 100%	7,516 94% (As of 6/30/19) (21% Medicaid/ uninsured families)	proven to increase parents reading to their children by 2.5 times, improve children's language development by 3-6 months and increase the likelihood of children's books in the home by 2.5 times. A child's language development and vocabulary are directly linked to 3rd grade reading scores which predict high school graduation rates, a critical indicator of health. A child entering kindergarten one year behind in reading has a 26% chance of dropping out of high school and a child three years behind has a 55% chance. In comparison, a child reading at grade level or better has a dropout rate of less than 10%. According to Healthy People 2020, individuals who do not graduate high school are more likely to self-report overall poor health. They also more frequently report suffering from at least 1 chronic health condition—for example, asthma, diabetes, heart disease, high blood

				pressure, stroke, hepatitis, or mental health challenges—than graduates. Ultimately, finishing more years of high school, and especially earning a high school diploma, decreases the risk of premature death.
Action: Early Childhood Home Visitation Expansion				90% of brain development happens by age 5. By identifying the most vulnerable new families and infants early, steps can be taken to help ensure these children have a strong start that fosters a lifetime of health. High risk families with first time births receive up to weekly home visits to educate parents on child development and parenting practices, provide health and development screenings and referrals, and provide support needed to create a stable, nurturing early environment. Evaluation of Parents as Teachers home visitation model shows: • Children's developmental delays and health problems are detected early (Well Child Visit rates improved) • Children enter kindergarten ready to learn and the achievement gap is narrowed • Children achieve school success into the elementary grades • Parents improve their
• Number of hospitals with Home Visitation referral	2	4	4	
• Number of annual Home Visitation assessments	45	300	317 As of 9/30/19	
• Number of Child Abuse and Neglect substantiations among enrolled Home Visitation families	n/a	0	0 In 2018, data for 2019 not available yet	

				parenting knowledge and skills • Child abuse and neglect is prevented • Parents are more involved in their children's schooling • Families are more likely to promote children's language and literacy

Additional efforts:

- Improve Well Child Visit rate from 77.52 in 2018 to 79.4% as part of TC primary care population health improvement effort
- *2018 Read Well Be Well* employee volunteer reading initiative in 7 elementary schools across all markets. 208 team members read to 2,268 children in grades 4K-3rd grade. Totaled 6700 minutes over 336 reading sessions.
- *2019 Make a Difference Day "Mystery Buses"* engaged 300 TC and Partner Business employees volunteering at 10 non-profit locations across all hospital markets focused on early childhood and youth.
- Hosted 25 matches through *Backyard Buddies,* mentoring partnership with TCRMC Neenah, Children's Hospital Fox Valley, Roosevelt School and Best Friends
- 2017 Fox Cities CHAT plunge on Early Childhood prompted effort to improve ASQ screening process/rate; piloted ASQ screening process with Winnebago County and Oshkosh TC clinic
- New London and Shawano CHAT Teams leading Trauma Sensitive Community efforts. New London educated 3,000+ in ACEs and TIC. Shawano hosting St A's statewide training for 30 trainers October 2019. Majority from Shawano area. UW Extensions in both communities serving as sustainable hub for TIC education.
- Shawano CHAT Team led Shawano Area School District policy change resulting in later school start times for teens.
- 2017-2019 Sponsorship of local non-profit initiatives related to early childhood/youth: $188,693
- 2017-2019 ThedaCare employee volunteer hours related to early childhood/youth: 52,472

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Mental Health/Opioids

Goal: ***People in ThedaCare 9-county service area have the support they need to lead mentally healthy lives free of reliance on alcohol or drugs.***

Community Level Indicators:

- ***Self-Reported Poor Mental Health Days***
- ***Rate of opioid related discharges in NEW***
- ***Rate of high school seniors who report being sad or hopeless for 2 weeks in row/stopped activities***

	Baseline 1/1/17	Target 12/31/19	Current 10/30/19	The Why
Action: Access to Behavioral Health Services				The state of mental health, access to mental health services and drug abuse, in particular opioid addiction, were named among top 3 health problems across all markets in both the 2015 and 2018 CHNAs.

• NEW Mental Health Connection Website (myconnectionNEW.org)
  ○ # hits
  ○ # online screenings completed
  ▪ % will seek help
	0
	0
	0
		n/a
		n/a
		n/a
			143,000 (2017-present)
			1400
			64%	

• Behavioral Health treatment access LM Julie ○ Outpatient psychiatry ▪ Number on wait list ▪ Days to initial evaluation ▪ Days to urgent evaluation ○ Recovery ▪ Days to 3rd next available ○ Outpatient Mental Health ▪ Days until 3rd next initial evaluation	685 (Sept 2016) 171 16 13 Midway 18 Waupaca 26 New London 45 Shawano 32 Encircle 20 Cancer Center 18 Oshkosh 28 Neenah N/A	0 Same day/week (all referrals touched) Same day/same week Same week	110 n/a 1 Midway 0 Waupaca 7 New London 4 Shawano 3 Encircle 11 Cancer Center n/a Oshkosh 1 Neenah 29	Self-reported number of mentally unhealthy days in past 30 days has been increasing across almost all markets since 2012. People in need of behavioral health services have waited months to receive care and access to care in rural markets has been particularly challenging.
Action: Substance Abuse – Opioids				The drug overdose death rate in Northeast Wisconsin has quadrupled from 2000 to 2016, rising from 2.7 deaths/100,000 population to 12.5 deaths/100,000. These deaths were largely driven by prescription opioids. The rate of opioid related hospital discharges in NE Wisconsin has more than doubled in last 10 years, from 122/100,000
• "Sources of Strength" High School Program ○ # Urban High Schools implementing (thru NEW MH Connection) ○ # Rural High Schools implementing	0 0	14 6 rural schools implementing (by 12/31/19)	17 6	
• Opioid Awareness Campaign ○ Calls to WI Addiction Recovery	0	300	271	

Hotline			(Campaign launch March 2019)	population in 2006 to 331/100,000 in 2016. Curtailing the amount of opioids available through prescribing practices and drug take-back/drop-box efforts, ensuring their appropriate use once prescribed, and providing effective treatment, including Medically Assisted Treatment options for those who become addicted are all important strategies to address the epidemic. In addition, working upstream to build resiliency in youth to strengthen mental health, and reduce risky behaviors in the first place provides the greatest return. This is the purpose of the *Sources of Strength* evidence-based program.
• Drug Drop Boxes ○ # Hospitals with boxes	0	6 (WR not eligible)	6	
• Clinical initiatives ○ % of call groups to receive metrics on opioid prescribing ○ # certified Medically Assisted Treatment providers (with infrastructure support)	0 n/a	100 5	0 Prescribing data dashboard to be available 11/19 6	
Additional efforts: • Fox Cities and Wild Rose CHAT Teams hosted Addiction Plunge August 2019. More than 100 community leaders participated resulting in new efforts to develop recovery coaching capacity, explore a Substance Use Coalition, expand sober living options, and improve access. The FC CHAT Team approved $3000 toward facilitation of Substance Use coalition development. • Waupaca CHAT supported launch of recovery coalition. Explored a recovery coach pilot for Waupaca ED. • Provided promotional support for Shawano Drug Take back campaigns in Waupaca and Shawano. • TCBH working with Catalpa and Shawano School District to explore providing MH counselors in Shawano schools. Catalpa				

Health launched in Waupaca in 2019.

- Shawano and Waupaca CHAT Teams led launch of Drug Courts in their respective counties.
  Waupaca - 2017-19 to date 56 referrals, 27 enrolled, 8 graduated. Known savings for 8 graduates totals $606,447.36 (incarceration cost vs drug court participation costs)
  Shawano - -launched in October 2018, 6 enrolled and 38 referrals to date (October 2019), no graduates yet
- MAT use of Vivitrol piloted in Waupaca and expanded to Shawano and Appleton North
- Provided $5000 in financial support of study regarding teen suicide-related behaviors in partnership with Medical College of Wisconsin/NEW Mental Health Connection
- Waupaca CHAT established two Oxford Recovery Houses. Men's house opened in October 2019 and has served 12 people; Women's house opened May 2019 and has served 9 people. 5 of the participants have also been involved with Drug Court
- Waupaca CHAT hosted Social Connection Plunge that launched community book read on "Deepening Community" by Paul Born, a Neighborhood Partners initiative, support for Rock the Block, and "Turquois Tables" at community events
- Mentoring initiatives launched through CHAT Teams in Berlin, Waupaca, Oshkosh and Wild Rose serving more than 500 youth.
  Waushara County –Multigenerational Mentoring Program for 2019 has had 23 volunteers and 309.5 hours volunteered by the Seniors. Student volunteer hours total 20.25.
  Berlin – B&GC 2018-19 school year served 28 matches, 2019-20 school year, to date, served 18 matches; expanded to Green Lake School District in 2019-20 school year, served 10 matches
  Waupaca – Big Brothers Big Sisters new partnerships with Waupaca Foundry and Waupaca Middle School resulted in more "littles" being matched. 35 kids served by 35 mentors for a total of 1225 hours. The new partnerships more than doubled the kids served from 13 in 2017 and 12 in 2018.
- Existing mentoring efforts supported in Shawano and Fox Cities. Matched physician funding for Boys & Girls Club Shawano totaling $60,000 over 3 years.
- Launched Trauma Sensitive Communities in New London and Shawano. Supported TIC in Fox Cities through United Way. Trauma Sensitive Community curriculum from NL is expanded to Waupaca County in a new partnership with UW Ext and Leadership Waupaca County.
- Participating in leading efforts for Regional Social Connection/Belongingness
- 2017-2019 Sponsorship of local non-profit initiatives related to mental health/substance abuse:$106,300
- 2017-2019 ThedaCare employee volunteer hours related to mental health/substance abuse: 2,278

Obesity

Goal: ***People in ThedaCare 9-county service area live at a healthy weight.***

Community Level Indicators:

- ***Overweight and obese (2017 data)***
  - ***Adult (75.1%)***
  - ***Children (28.65%)***

	Baseline 1/1/17	Target 12/31/19	Current 10/23/19	The Why
Action: "Weight of the Fox Valley" Tri-County Initiative				Overweight and obesity are drivers of preventable chronic disease and reduced quality and length of life. It was ranked among the top 3 health priorities in both the 2015 and 2018 CHNAs. Diseases linked to obesity are many including heart disease, cancer, diabetes, osteoarthritis, orthopedic problems, high blood pressure, stroke, sleep apnea, and mental illness such as clinical depression, anxiety, and other mental disorders.
• Additional organizations offering obesity-related worksite wellness programs	0	30	23	
• Early Care & Education programs adding strategies for serving WI grown fruits and vegetables	21	31	29	

• Breastfeeding friendly designations
  ○ Early Care & Education programs
  ○ Worksites
	
	29
	0
		
		39
		10
			
			37
			4	

• Wayfinding signage on bicycle and pedestrian trails ○ Linear miles	 0	 50	 25.1	

○ # signs	0	100	101	Obesity also contributes significantly to healthcare costs. Each year obesity-related conditions cost over $150 billion and cause an estimated 300,000 premature deaths in the US. As a person's BMI increases, so do the number of sick days, medical claims and healthcare costs. For instance: •Obese adults spend 42% more on direct healthcare costs than adults who are a healthy weight. •Per capita healthcare costs for severely or morbidly obese adults (BMI >40) are 81% higher than for healthy weight adults.
• Complete Streets policies ○ # Municipalities passing policies	2	7	5	

Additional efforts:

- Provided financial support of Farmers Markets across service areas
- Along with United Way, championed transformation of "Weight of the Fox Valley" into more robust "LiveWell Fox Valley" model. Pending commitment from 5 health systems.
- Waupaca – Living the Waupaca Way – hired a Farmer's Market Coordinator, more than doubled vendor participation, improved music and activities at the market; hired a Community Garden coordinator; Farm to Table dinner 100 tickets sold and raised $1,292 in 2019; participated in Healthy WI Leadership Institute; took on leadership of the Fun Run
- Attained Preliminary Status as Diabetes Prevention Program provider by CDC. Thoughout application phase of 2017-2019 enrolled 159 people. On average participants reduced risk of developing diabetes by 58%. Lifestyle Intervention Program

enrolled 172 people since 2017 with average weight loss of 22 lbs, HAT score improvement of 15 points, reduction of prediabetes among 53%, and 44% reduction in metabolic syndrome. Enhancing process to allow providers to more readily refer people to the program. The Coronary Health Improvement Program enrolled 308 people since 2017 with an average drop in BMI of 5% and 20% drop in lipids.

- Major sponsor of American Heart Association resulting in $203,500 in fundraising from Heart Ball, Go Red For Women and Heart & Stroke Walk; more than 2.6 million impressions on social media and traditional media; 450 people trained in hands only CPR including 35 students from Little Chute High School who continue to train Fox Cities community members at local businesses/schools/churches/community events
- Financial and in-kind Support of rural nutrition and physical activity coalitions including FRESH- Shawano, Living the Waupaca Way- Waupaca which included securing grant from Healthy Wisconsin Leadership Institute training and hosting annual Farm to Table dinner
- Sponsor multiple Walks and Runs including Bike the Barn Quilts in Shawano; Waupaca Triathlon; American Cancer Society Sole Burner, Fox Cities Marathon
- 2017 *Good to Go* ThedaCare employee volunteer initiative in 7 area schools to encourage healthy eating, active living - 289 TC team members donated 757 volunteer hours
- 2018 Sponsorship of local non-profit initiatives related to obesity: $153,900
- 2017-2019 ThedaCare employee volunteer hours related to obesity: 2,534

Disparities

Goal: *All people within ThedaCare 9-county service area have the opportunity to achieve optimal health.*

Community Level Indicators: • **High School graduation rates** • **Percent of families living below ALICE and poverty levels**	**Baseline 1/1/17**	**Target 12/31/19**	**Current 1/1/19**	**The Why**
Action: STAR Program (Addressing African American academic success)				The 2015 and 2018 CHNAs indicates that not all people in the ThedaCare service area are achieving comparable

• STAR Program • # African American students enrolled • Graduation rate • #/% on track to graduate (Discontinued this metric; found not applicable) • Of those not on-track to graduate from semester 1 to 2, % made progress toward being on-track with credit accrual	190 (May 2018) 72.5% Appleton 70.0% Menasha 51% n/a	400 -- --	450 (2018-2019 year) 86% (Appleton and Menasha combined) n/a 40%	levels of health. People of color, low-income, less education and those living in rural markets face greater struggles to achieve optimal health. Addressing health disparities is increasingly important as the population ThedaCare serves becomes more diverse. These vulnerable populations are more likely to be uninsured, face barriers to accessing care, and have higher rates of certain conditions compared to Whites and those at higher incomes.
Action: Rural Health Initiative			As of 10-21-19	Access to healthcare services is particularly challenging for farm families and those living in rural communities. Higher poverty rates, a growing aging population, proximity to services coupled with the independent nature of farmers and cost of care lead to low utilization of services important to understand personal health and stay healthy.
• Number of rural individuals served per year LM Rhonda • # health screenings per year ○ Unmanaged chronic health conditions identified • Number of referrals made to health care providers per year	339 548 290 212	230 (90 Latino) 375 170 165	176 (2016-18: 7,651) 323 (2016-18: 1,838) 145 (2016-2018: 691) 116 (2016-2018:	

			728) (Lower annual #s due to 11% decrease in farms)	
Action: POINT (Poverty Outcomes Improvement Network)				Poverty and health are inextricably linked. The difference in life expectancy between the poorest and richest people in the United States is between 10 and 15 years. • Early childhood adversity and poverty is a factor that affects not only brain architecture and [neurologic and endocrine] function, but affects the probability of lifelong illness, including cardiac disease and diabetes. • Adults living in poverty are much more likely to have inflammatory diseases with an increased risk for heart attack and stroke. • People living in poverty are more likely to smoke putting them at higher risk for lung cancer and respiratory conditions.
• POINT Regional Poverty Initiative • ○ % living below poverty rate ▪ Outagamie ▪ Winnebago ○ # Homes in poverty with female head of household ▪ Outagamie ▪ Winnebago ○ % of individuals earning > $18/hour	9.9 (12/31/15) 11.7 (12/31/15) 2,582 1,407 3.5	n/a n/a 1,937 1,055 7	7.1 (12/31/18) 11.1% (12/31/18) 1,316 1,342 5	

				• People in poverty have increased hunger and tend to purchase the cheapest food available which is usually empty calories – high-calorie, high-fat food. In addition, people may live in food deserts with nowhere to get fresh vegetables but plenty of access to fast food. • Almost half of children who live in poverty have mothers with at least some symptoms of depression, because of the stresses of raising a family in poverty. Mothers who are depressed interact with their children differently. Those interactions the lack of stimulation and socio-emotional connections and can have long-term effects, if not lifelong effects, on children.
Additional efforts: • Continue support of Cuidate Latino Teen Pregnancy Prevention Program at FQHC • New London CHAT Team hosted plunge on Rural Transportation in 2018 resulting in new bike-share program with Tyson Foods				

and proposed expansion of Fox Cities-based “Making the Ride Happen” services to Waupaca County.

- 2018 Sponsorship of local non-profit initiatives related to disparities:$96,000
- 2017-2019 ThedaCare employee volunteer hours related to disparities: 8,709

Additional Strategic Initiatives

- **Imagine Fox Cities**
  ThedaCare played a critical role in the development and launch of *Imagine Fox Cities* visioning initiative which engaged the entire Fox Cities region in a discovery and discernment process to understand what people think about their well-being today, what they expect their well-being to be in the future, and articulate a vision for generations to come that will guide local decision-making. This vision sets the larger context for advancing health and well-being across the region.

- **ReThink Health**
  Through consultants engaged with Imagine Fox Cities, brought leaders from ReThink Health to Fox Cities to participate in RWJF grant to explore how local institutions can invest differently to propel our community toward the new vision. ThedaCare will play a future lead role.